knutson
CHIROPRACTIC

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Today's Date:_____/_____/_____

Your Name:_____Name you prefer to be called:_____
Address: _____Apt#:_____ City _____, St._____ Zip_____
Sex: ____M ____F Birthdate: _____/_____/____ E-mail:_____
Age:_____ Occupation:_____

Best Place to reach you: ◊Home ◊ Work ◊ Cell ( )_____ AM PM Anytime

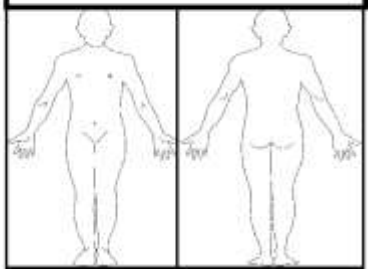
Spouse's/Partner's Name (if applicable): _____ Spouse's Birthdate (insurance purposes):____/____/___
Children's Names and ages (if applicable): _____
Emergency Contact Name:_____ Phone:_____
Are your symptoms related to an accident? Y N ____automobile _____work ____other date __/__/__
Motor Vehicle Accident only Insurance: ___
Relationship to insured: __self __spouse __child __other:_____
Primary Care Doctor- name and facility:_____
May we contact him or her about your care? Y N Were you referred by him or her? Y or N
How did you hear about us?: _____

On a Scale of 0—10, I rate my discomfort as follows:
(zero being no pain, 10 being the worst pain I have ever felt=ER visit)

Neck or Shoulder Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Midback Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Low Back or Leg Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Other:_____	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain

Complaints:
1) _____
2) _____
3) _____
Date of Injury ____/____/_____ How did they start ?
_____
_____
_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING BELOW



What types of therapies have you tried for these problem(s) or to improve your health over-all:

__diet modification __fasting __vitamins/minerals __herbs __homeopathy __chiropractic __acupuncture __conventional drugs
__other:_____

Do you experience any of these general symptoms EVERY DAY?

__Debilitating fatigue	__Shortness of breath	__Insomnia	__Constipation	__Chronic pain/inflammation	___Change in wart or mole
__Depression	__Panic attacks	__Nausea	__Fecal incontinence	__Bleeding	___Nagging cough/ hoarseness
__Disinterest in sex	__Headaches	__Vomiting	__Urinary incontinence	__Discharge	___Blood in stool or urine
__Disinterest in eating	__Dizziness	__Diarrhea	__Low grade fever	__Itching/rash	

Current medications (prescription or over-the-counter): _____
_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you consider yourself: __underweight __overweight __just right **Your weight today:** _____

How often do you experience your symptoms?
__Constantly (100% of day)
__Frequently (51-75% of day)
__Occasionally (26-50% of day)
__Intermittently (0-25% of day)
How would you describe your symptoms?
__Sharp __Shooting __Dull Ache __Burning __Numb __Tingling
Other:_____
How are your symptoms changing?
__Getting Better __Not Changing __Getting Worse

Does your pain ever wake you from a sound sleep? Yes ___ No ___
Are you losing weight now without trying? Yes ___ No ___
Do you have a headache or head pain that is unlike any you have had before? Yes ___ No ___
Have you ever been or are you now being pressured or forced to engage in any type of Sexual activity? Yes___ No___

Patient Signature:_____ Date:____/____/_____

** By signing above, all information on this intake form is true and accurate to the best of my knowledge.

Medical History
__ Arthritis
__ Allergies/hay fever
__ Asthma
__ Alcoholism
__ Alzheimer's disease
__ Autoimmune disease
__ Blood pressure problems
__ Bronchitis
__ Cancer
__ Chronic fatigue syndrome
__ Carpal tunnel syndrome
__ Cholesterol, elevated
__ Circulatory problems
__ Colitis
__ Dental problems
__ Depression
__ Diabetes
__ Diverticular disease
__ Drug addiction
__ Eating disorder
__ Epilepsy
__ Emphysema
__ Eyes, ears, nose, throat problems
__ Environmental sensitivities
__ Fibromyalgia
__ Food intolerance
__ Gastroesophageal reflux disease
__ Genetic disorder
__ Glaucoma
__ Gout
__ Heart disease
__ Infection, chronic
__ Inflammatory bowel disease
__ Irritable bowel syndrome
__ Kidney or bladder disease
__ Learning disabilities
__ Liver or gallbladder disease (stones)
__ Mental illness
__ Mental retardation
__ Migraine headaches
__ Neurological problems (Parkinson's, paralysis)
__ Sinus problems
__ Stroke
__ Thyroid trouble
__ Obesity
__ Osteoporosis
__ Pneumonia
__ Sexually transmitted disease
__ Seasonal affective disorder
__ Skin problems
__ Tuberculosis
__ Ulcer
__ Urinary tract infection
__ Varicose veins
Other _____
_____

Medical (Men)
__ Benign prostatic hyperplasia
__ Prostate cancer
__ Decreased sex drive
__ Infertility
__ Sexually transmitted disease
Other _____
_____

Medical (Women)
__ Menstrual irregularities
__ Endometriosis
__ Infertility
__ Fibrocystic breasts
__ Fibroids/ovarian cysts
__ Premenstrual syndrome (PMS)
__ Breast cancer
__ Pelvic inflammatory disease
__ Vaginal infections
__ Decreased sex drive
__ Sexually transmitted disease
Other _____
Date of last GYN exam _____
Mammogram q + q —
PAP q + q —
Form of birth control _____
# of children _____
# of pregnancies _____
__ C-section _____
Age of first period _____
Date - last menstrual cycle_____
Length of cycle _____ days
Interval of time between cycles _____days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
__ Surgical menopause
__ Menopause

Family Health History (Parents and Siblings)
__ Arthritis
__ Asthma
__ Alcoholism
__ Alzheimer's disease
__ Cancer
__ Depression
__ Diabetes
__ Drug addiction
__ Eating disorder
__ Genetic disorder
__ Glaucoma
__ Heart disease
__ Infertility
__ Learning disabilities
__ Mental illness
__ Mental retardation
__ Migraine headaches
__ Neurological disorders (Parkinson's, paralysis)
__ Obesity
__ Osteoporosis
__ Stroke
__ Suicide
Other _____

Health Habits
__ Tobacco:
Cigarettes: #/day _____
Cigars: #/day _____
__ Alcohol:
Wine: #glasses/d or wk _____
Liquor: #ounces/d or wk _____
Beer: #glasses/d or wk _____
__ Caffeine:
Coffee: #6 oz cups/d _____
Tea: #6 oz cups/d _____
Soda w/caffeine: #cans/d _____
Other sources _____
__ Water: #glasses/d _____

Exercise
__ 5-7 days per week
__ 3-4 days per week
__ 1-2 days per week
__ 45 minutes or more duration per workout
__ 30-45 minutes duration per workout
__ Less than 30 minutes
__ Walk - #days/wk _____
__ Run, jog, other aerobic - #days/wk_____
__ Weight lift - #days/wk _____
__ Stretch - #days/wk _____
Other _____

Nutrition & Diet
__ Mixed food diet (animal and vegetable sources)
__ Vegetarian
__ Vegan
__ Salt restriction
__ Fat restriction
__ Starch/carbohydrate restriction
__ The Zone Diet
__ Total calorie restriction
__ Specific food restrictions:
__ dairy
__ wheat
__ eggs
__ soy
__ corn
__ all gluten
Other _____

Food Frequency
Number of servings per day:
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables _____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish _____

Eating Habits
__ Skip meals - which ones _____
__ One meal/day
__ Two meals/day
__ Three meals/day
__ Graze (small frequent meals)
__ Generally eat on the run
__ Eat constantly whether hungry or not

Current Supplements
__ Multivitamin/mineral
__ Vitamin C
__ Vitamin E
__ EPA/DHA
__ Evening Primrose/GLA
__ Calcium, source_____
__ Magnesium
__ Zinc
__ Minerals, describe _____
__ Friendly flora (acidophilus)
__ Digestive enzymes
__ Amino acids
__ CoQ10
__ Antioxidants (e.g., lutein, resveratrol, etc.)
__ Herbs
__ Homeopathy
__ Protein shakes
__ Superfoods (e.g., bee pollen, phytonutrient blends)
__ Liquid meals (Ensure)
Others_____
_____

I Would Like To:
ENERGY - VITALITY
__ Feel more vital
__ Have more energy
__ Have more endurance
__ Be less tired after lunch
__ Sleep better
__ Be free of pain
__ Get less colds and flu
__ Get rid of allergies
__ Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
__ Stop using laxatives and stool softeners
__ Improve sex drive

BODY COMPOSITION
__ Lose weight
__ Burn more body fat
__ Be stronger
__ Have better muscle tone
__ Be more flexible

STRESS, MENTAL, EMOTIONAL
__ Learn how to reduce stress
__ Think more clearly and be more focused
__ Improve memory
__ Be less depressed
__ Be less moody
__ Be less indecisive
__ Feel more motivated

LIFE ENRICHMENT
__ Reduce my risk of degenerative disease
__ Slow down accelerated aging
__ Maintain a healthier life longer
__ Change from a "treating-illness" orientation to creating a wellness lifestyle

Other: